HM Government

Changes to Primary Care Trusts

Government Response to the Health Committee's Report on Changes to Primary Care Trusts

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Introduction

1. This Command Paper sets out the Government's response to the Health Select Committee's Second Report of Session 2005–06, *Changes to Primary Care Trusts*.

2. The Government welcomes the Committee's examination of the issues surrounding the reconfiguration of Primary Care Trusts and welcomes, too, the opportunity to set out in more detail the background to these changes and the benefits that will follow for patients.

Background

3. Since Primary Care Trusts (PCTs) were first established in 2000, there have been a number of changes to improve health services for patients. In 2000 the Government published the NHS Plan. This set out a 10-year programme to radically improve the NHS in England in line with the public's priorities for the health service. To realise the vision set out in the NHS Plan, the Government is providing the largest ever sustained investment in the National Health Service.

- Funding of the NHS has increased from £34.7 billion in 1997/98 to £69.7 billion in 2004/05.

- By 2007/08, spending on the NHS will have increased to over £92 billion.

4. The Government recognises that extra investment alone is not enough to transform services and patient care. Investment must be accompanied by reform, including new ways of working. Using this dual approach, the NHS has made huge achievements over the past five years, including:

- **Reduction in waiting times** – for instance, at the end of 2005, the maximum waiting time for the first appointment with a consultant fell to just 13 weeks and the maximum waiting time for hospital treatment came down to six months.

- **More staff** – between September 1997 and September 2004, the number of doctors employed in the NHS has increased by more than 27,400 and the number of nurses employed in the NHS has gone up by more than 78,600.

- **More hospitals** – there are currently 44 NHS Treatment Centres and 21 Independent Treatment Centres now open and delivering faster, quality care and choice for patients. Two further treatment centres are due to open shortly and eight more independent treatment centres are expected to open by 2007. There are also 128 Private Finance Initiatives and 12 public capital schemes worth £19.3 billion going ahead and counting towards the NHS Plan target of 100 new hospitals open by 2010. Eighty-nine of these new hospitals are already open or being built.

- **Improved access to emergency care** – over 19 out of 20 people who go to accident and emergency are now seen and treated in less than four hours.

5. A great deal has been achieved during the last five years, but we need to go even further. The challenge now is to create an NHS that is self-improving because staff and organisations have the incentive and freedom to respond to what their local communities want and need. Nearly 90 per cent of people's everyday contact with the NHS takes place in primary care settings such as GP surgeries, so it makes sense when improving care to focus on primary and community services.

6. This means moving more services such as diagnostics, minor operations and other treatments out of hospitals and closer to where people live, wherever it is safe and appropriate to do so. It is better for patients and taxpayers if long-term conditions like diabetes and heart disease, as well as care for older people, are dealt with in the local community. This needs to be done in a way that supports people to remain out of hospital and reduces bureaucracy so that more money goes into frontline care. Along with all of this, there needs to be a stronger emphasis on prevention – helping people to stay well – and an overall commitment to ensuring all our communities get the range of services they need.

The Health Reform Strategy

7. For the last five years, the Department of Health has relied heavily on national targets to drive improvements and push up the quality of care. Although it has been essential in achieving improvements in the short term, a truly patient-led NHS cannot be run from Whitehall and national targets are not a long-term solution to creating a patient-led NHS.

8. Instead, we need to embed the reforms and change into the culture of the NHS as well as into its system. Good practice in almost every aspect of care can be found somewhere in the NHS, but best practice needs to become the norm everywhere. So we need to ensure that, throughout the whole service, there are the right incentives for continuous improvement, innovation and achieving better value for money. And we need to use the remaining years of very fast financial growth to create that new system.

9. In order to create a self-improving, patient-led NHS, the Government is implementing a reform programme with four related strands:

- **More choice and a much stronger voice for patients.** This includes a new system of commissioning services (including Practice Based Commissioning budgets) and better information for the public about health and health services to support them in making the right choices about their care.

- **More diverse providers, with more freedom to innovate and improve services.** This includes more NHS Foundation Trusts and involving the independent sector in service provision.

- **Money following the patient**. This ensures that the best and most efficient care providers are rewarded and that the rest have a real incentive to improve.

- **A framework of regulation and decision-making.** This will guarantee patients quality, fairness, equity and value for money.

10. The Government has also outlined its vision for improvements to community services in *Our health, our care, our say: a new direction for community services* which was published on

30 January 2006. This White Paper proposes reforms to community health and social care services designed to increase the focus on prevention and on promoting health, independence and wider well-being; improve access and increase the choice and control that people have over their own care; deliver more care closer to home; reduce inequalities; and integrate social care and health services better to suit individuals' needs.

Rationale for the changes to Primary Care Trusts

11. All these reforms mean that the NHS of 2006 is very different to the NHS of 2000. As Practice Based Commissioning is rolled out, choice becomes a reality for more and more patients; the number of services covered by Payment by Results is expanded; and the number of NHS Foundation Hospitals grows, PCTs cannot stand still. They need to become stronger, more strategic organisations with a more focused role. In particular, they will need to:

- commission better services for patients;
- work more closely with local government; and
- ensure that we get the best value for money from the system.

12. As the Health Select Committee has observed, in many places the NHS has already begun making the changes necessary to rise to this challenge.

13. Against this background, the Government welcomes the Health Select Committee's support for improving commissioning in the NHS and notes the recommendation that reconfiguration could have proceeded in a more evolutionary way. However, while some PCTs may have benefited from this approach, the Government considers that others would have suffered. Commissioning has not developed as effectively as it should have over the last five years. Best practice clearly exists in some areas, but it is far from universal.

14. No single organisational model will ever fit all. However, the Government believes there was a need for a clear national framework that would allow all PCTs to meet the same standards in commissioning that the very best are already achieving. *Commissioning a patient-led NHS*, published by the Department of Health in July 2005, sets out clearly what that framework would be and what will be required of Strategic Health Authorities (SHAs) and PCTs.

Commissioning a patient-led NHS

15. *Commissioning a patient-led NHS* sets out proposals for reconfiguring SHAs and PCTs. This document makes it clear that there is no single blueprint for the future shape of PCTs and SHAs. In addition to outlining how the reconfiguration of organisations should be managed, *Commissioning a patient-led NHS* also explains that there will be a national PCT development programme that will be key to supporting PCTs in improving their commissioning capability.

16. The process that the Government has put in place for reconfiguring PCTs has enabled and encouraged local stakeholders to shape proposals during a 'pre-consultation' phase and to have a continued say during the formal local consultations – a process which is still ongoing.

17. To help ensure that future PCTs are designed locally, SHAs were invited to lead the process and work with their local stakeholders between July and October 2005 to develop proposals for ensuring that the shape of their PCTs was fit for purpose against a set of national criteria.

18. SHAs submitted their proposals for the reconfiguration of PCTs in their local areas to the Department of Health on 15 October 2005. These were then considered by an independent external panel and Ministers. Formal local consultations on the proposals began on 14 December 2005 and will continue for 14 weeks until 22 March 2006. This will give local stakeholders longer than the usual 12-week consultation period to express their views on the future shape of their PCTs.

19. Once the local consultations have concluded, SHAs will make recommendations to Ministers. New SHAs are expected to come into force from July 2006 and new PCTs from October 2006. A simultaneous consultation is under way on proposals for the reconfiguration of ambulance trusts. Details about this are outside the scope of this report, but further information can be found at www.dh.gov.uk.

Managing the transition

20. The Government notes the Health Select Committee's concern that the reconfiguration carries the risk of destabilising organisations and setting back the NHS. However, we believe that the changes that are being put in place will, in fact, have the opposite effect. PCTs must develop and change if they are succeeded to implementing the challenging reform programme they face. They cannot stand still, nor can the Department of Health simply stand back and expect progress without indicating a clear future direction. Action was needed and that is what *Commissioning a patient-led NHS* delivers.

21. The Committee also expressed concern about the impact of these changes on NHS staff. While the Government acknowledges that change can be unsettling for staff working in the organisations affected, it has put in place measures to support staff through this transition. A human resources framework was published in December 2005 specifically to address these issues and full staff consultation about proposed transfer of employment will take place once the local consultations on the reconfiguration proposals draw to a close.

22. The Government does not believe that patient care will suffer as a result of the changes that are being made. The changes to PCTs are intended to strengthen their capacity to commission effective services in response to the needs of their patients. Patients will benefit, not suffer, from these services.

23. The Department of Health has agreed clear transition arrangements with SHAs so that all will remain accountable for ongoing performance and for agreeing local delivery plans for 2006/07. Additionally transition leads for SHA clusters have been identified to ensure business continuity should new SHAs be agreed by Ministers following consultation.

Benefits of changes to PCTs

24. As stated, our intention is for PCTs to become stronger organisations with a more focused role, especially in relation to the following:

Commissioning better services for patients

25. PCTs, in partnership with GP practices and other local partners must become the focal point for planning, designing and shaping local health services, health improvement services and health protection services that best meet the needs of their communities. But they must also deliver value for money from the resources allocated to them.

26. It will be their job to ensure that the range and scale of primary care itself are adequate; that patient access to primary care is satisfactory; and, where needed, that there is an increase in primary care capacity, bringing in new service providers as necessary.

27. *Commissioning a patient-led NHS* sets out the expectation that there will be universal coverage of Practice Based Commissioning by December 2006. This means that clinicians will have a leading role in deciding what services are commissioned locally, to suit the choices their patients and communities are making. This will bring commissioning closer to local people, rather than making it more remote as the Committee indicates.

28. Practice Based Commissioning will enable GPs and other primary care professionals to better manage the 'care pathway' for individual patients. It will help practices reduce the need for hospital admissions by encouraging more services to be located closer to the patient's home, and it will help improve services for people living with long-term conditions, and for people who have recently been discharged from hospital.

29. PCTs will support and manage the operation of Practice Based Commissioning in their areas. They will need to agree budgets with practices and ensure that these practices are using available information – for example about referral patterns – on which to base commissioning decisions. Practices will be free to cooperate with other practices to take full advantage of Practice Based Commissioning. On behalf of GPs, other primary care professionals and local patients, PCTs will continue to be responsible for negotiating and managing contracts and ensuring the local health budget is being spent as effectively as possible.

30. As noted in paragraph 15, the Department of Health is preparing a national PCT development programme. This will include a tool to assess the capability of PCTs in key functions such as commissioning and strategic planning as well as the financial viability of the organisation. The diagnostic tool will be piloted in summer 2006 and rolled out over the autumn of 2006 for PCTs.

Working more closely with local government

31. *Commissioning a patient-led NHS* also seeks to strengthen relationships between healthcare and Local Authorities by bringing their boundaries closer together. Currently just over 40 per cent of PCTs are co-terminous with Local Government boundaries. Subject to the outcome of local consultations, we expect this will rise to nearly 80 per cent and ambulance trusts and SHAs are likely to see their boundaries much more closely aligned with those of the Government Offices for the Regions. These changes, if made, will enable organisations to work together more effectively to tackle priorities such as reducing health inequalities and improving care for those with long-term conditions.

32. New boundary changes will need to balance the size or scale with 'locality'. This means that where PCTs cover large areas, these will need to show that very good existing local partnerships will be retained and strengthened, and plans for PCTs covering small areas will need to demonstrate they are able to influence services and drive best value for money. The White Paper *Our health, our care, our say* (January 2006) includes further measures to improve joint working between the health and social care systems, and wider partnership working with other local services.

Ensuring that we get the best value for money from the system

33. Reconfiguration also provides an opportunity to deliver savings by reducing the number of organisations and greater sharing of 'back office' functions.

34. After completion, the reconfiguration of PCTs and SHAs is expected to deliver savings of £250 million every year for reinvestment in frontline services. PCTs are likely to prioritise investments in the Government's manifesto commitments such as additional palliative care services, improving access to cancer services and developments in mental health services.

PCTs as providers of services

35. While acknowledging the Committee's concern that there has been a lack of clarity over whether or not PCTs will continue to provide services, the Government believes this has now been made clear. The Secretary of State for Health informed Parliament on 25 October 2005 that: "District nurses, health visitors and other staff delivering clinical services will continue to be employed by their PCT, unless and until the PCT decides otherwise."

36. The White Paper published on 30 January built on this further. It explained that PCTs will be expected to assess all the services they commission, including those they directly provide, to ensure that they accord with the direction set out in the White Paper in terms of equity, quality and value for money. They will be expected to seek the views of people who use services as part of the assessment process, including thorough independent surveys.

37. They will also be expected to use benchmarking information to assess the performance of services against good practice and develop an improvement plan as part of their wider development programme, where needed. Where the outcome of these assessments indicates this is appropriate, PCTs will need to develop clear plans for improvement. This may include tendering for services either immediately or where improvement goals are not met after one year. Any changes in ownership for the provision of community services proposed by PCTs will involve full and formal consultation with staff before decisions are taken.

38. Where PCTs are continuing to provide services, they will be expected to have clear governance procedures in place to ensure there is no conflict of interest between their commissioning and provider functions. In doing this, PCTs will be accountable to SHAs and Local Authority Health Overview and Scrutiny Committees.

The Government's response to the Health Select Committee's recommendations and conclusions:

1. Besides cost savings, the Government has stated that the main aim of these reforms is to strengthen PCTs' commissioning function, as larger commissioning organisations, similar in size to old Health Authorities, will have increased bargaining power, and can be better aligned to local authority services. However, before discussing in detail the likely impact of the Government's proposal to restructure PCTs, it is important to note that PCTs were established only three years ago, at considerable cost to the taxpayer. A return to structures which are similar in size and function to previous Health Authorities raises important questions about why the shortcomings now being identified by the Government, including increased management costs and dilution of bargaining power, could not have been easily anticipated and addressed before PCTs' introduction three years ago. As we discuss later in this report, all restructurings are hugely disruptive, and to introduce a large scale

reconfiguration of NHS organisations only three years after the last root and branch reform of NHS organisations points to an ill thought-out approach to policy-making. (Paragraph 35)

Changes to Primary Care Trusts (PCTs) are being made at a time when the landscape of the NHS has changed significantly and the pressure to perform well has never been higher. As Practice Based Commissioning is rolled out across the NHS, as patient choice becomes a reality and as the number of services covered by Payment by Results is expanded, so the role of PCTs needs to change. They need to change and develop in order to deliver a self-improving NHS that provides better value for money for taxpayers and better services for patients. The reforms outlined in *Commissioning a patient-led NHS* will enable them to do this.

While restructuring can be disruptive, this is not change for change's sake. This change is necessary to equip the NHS to deliver the next stage of the reform programme. The NHS has been telling us for some time that structural change is necessary and *Commissioning a patient-led NHS* is a response to that – it is not a return to the old Health Authorities. Many PCTs had already started to merge or work collaboratively to create a stronger and more effective commissioning function able to secure the best possible healthcare for all patients in every local area. *Commissioning a patient-led NHS* brings more structure to this process, ensuring that there is consistency across the country and allowing all PCTs to learn from the best practice to date.

2. We are appalled at the continuing lack of clarity about whether or not PCTs will eventually divest themselves of their provider functions. This announcement was first made at the end of July, together with a firm timetable for its implementation, which was withdrawn in October. Various ministerial announcements have failed to clarify the position, and even our witnesses, drawn from the senior ranks of the NHS, could not agree about whether or not these changes would eventually happen, with many appearing genuinely bewildered. As far as we can see, the overall direction of travel in fact remains unchanged, and PCTs will ultimately divest themselves of provider services. We urge the Government to either confirm or deny this immediately. (Paragraph 46)

Our position on provision is clear: we will not instruct PCTs to divest themselves of service provision, nor will we impose any timetable. Further to this, we will support PCTs whether or not they choose to divest themselves of provider functions, provided that the approach they are taking is genuinely best for local patient care.

We have made this clear to the service, and as the Secretary of State said to Parliament on 25 October 2005: "District Nurses, health visitors and other staff delivering clinical services will continue to be employed by their PCT, unless and until the PCT decides otherwise" and, "any such decisions would be driven locally following our White Paper deliberations".

The Royal College of Nursing has said it "welcomes the reassurance that there is no policy requirement or timetable for PCTs to divest themselves of provision".

3. We are deeply concerned that neither Lord Warner nor John Bacon were able to give us a confident assurance that NHS staff potentially affected by these changes would be able to retain their NHS pensions. The Government must provide clear information as to whether existing NHS staff who are transferred to other providers, particularly in the private sector, as a result of these changes will be able to retain their NHS pensions. (Paragraph 47)

To confirm what Lord Warner and John Bacon said in their evidence session before the Committee, staff transferring to other providers are protected by the TUPE rules, which require the new

employer to provide broadly equivalent pensions provision. Transferring staff can choose to leave their existing (past) service in the NHS Pension Scheme when joining the new organisation, or to transfer all their rights to a new scheme.

As we have made clear, staff delivering clinical services will continue to be employed by their PCT unless and until the PCT decides otherwise. The recent White Paper, *Our health, our care, our say: a new direction for community services* commits us to working with our partners to explore what more could be done to give staff greater assurance on pension arrangements if they transfer to new enterprises delivering NHS services.

4. Perhaps most concerning of all is that these announcements about the future of PCT provided community services anticipate the outcome of the Government's flagship consultation *Your Health, Your Care, Your Say*, which is supposed to shape the Government's forthcoming White Paper on out-of-hospital care. For a Government to announce its intended direction of travel a full five months before its consultation on this subject comes to an end makes a mockery of the consultative process. Equally, if the Government is now committed to introducing changes to PCTs to a more relaxed, less prescriptive timescale, it is difficult to see why the announcement would not have been better made in a more measured, informed way, in the expected White Paper. (Paragraph 48)

We have been clear that *Commissioning a patient-led NHS* is not about service change, and that all decisions about community services will be subject to the White Paper.

As we have already stated, we will support PCTs who want to divest themselves of service provisions, but we will not *instruct* PCTs to do so, nor will we impose any timetable. What matters is getting the best services for each community – and that is what the White Paper focuses on.

5. One of our witnesses argued that the Government's handling of announcements surrounding *Commissioning a patient-led NHS* gives "a clear impression that the policy is being developed on the hoof". We agree. In our view, the numerous announcements and retractions about the divestment of PCTs' provider services, in advance of a White Paper consultation designed to canvass views on precisely this area, points to flawed and incoherent policy-making. (Paragraph 49)

Our position is clear: decisions about service provision will be a matter for PCTs to determine locally. In our proposals on 28 July 2005 we indicated that we were considering plans to require PCTs to reduce their service-provision functions by the end of 2008. Since then, we have listened to stakeholders, and reflected their views as our policy has developed. Far from being policy developed "on the hoof", this is a normal and appropriate response to the concerns we have heard.

6. The consequence of this, which could have easily been predicted before the July announcements, has been the destabilisation of a very valuable workforce whose support will prove essential to the implementation of the forthcoming White Paper. The insecurity and distraction that has been caused within NHS community health services demonstrates how damaging the repercussions of ill-thought through policy announcements can be, and we therefore recommend that the Department of Health carries out an immediate review of its internal systems to ensure that this does not happen again. (Paragraph 50)

The 1.3 million staff who work for the NHS are undoubtedly its most valuable asset. The vast majority of these staff will be unaffected by any restructuring, and frontline clinicians are highly unlikely to be directly affected by these changes. We believe that as we strengthen commissioning,

we will ensure not only better services for patients, but greater job satisfaction for staff working in primary care.

It is very important that organisational change is managed effectively. In conjunction with NHS employers and trades unions, we have developed a human resources framework to ensure our staff benefit from consistent and appropriate support throughout these changes.

In addition, a TUPE consultation will soon be undertaken to ensure that staff and trades unions have their full say on decisions which may affect their future employment.

The Government does not accept the Committee's criticism that the policy was ill-thought through. However, the Committee should know that Ministers and the NHS Chief Executive have recently reviewed the high-level structure of the Department of Health. Following this, the Department has established a new Policy and Strategy Directorate, and will be strengthening its processes for policy planning and co-ordination.

7. Although the stated aim of these proposals is to design a more patient-led NHS, evidence both from NHS bodies and from Patient and Public Involvement Forums confirms that patients and the public have not been adequately consulted. We find this unacceptable. If the Government truly believes in a patient-led NHS, it should have started its reforms with a patient-led consultation process, rather than the top-down process we are clearly seeing. (Paragraph 55)

Commissioning a patient-led NHS has involved a large amount of consultation which has been run at a local level.

In our proposals set out on 28 July 2005, we asked SHAs to engage with their stakeholders to develop proposals for reconfiguring their local PCTs. These proposals would then be subject to full local consultation. We asked SHAs to oversee this locally because solutions will vary in every part of the country.

Based on the proposals generated by that process, a formal local consultation process began on 14 December 2005. This will run for 14 weeks – longer than Cabinet Office guidance recommends – until 22 March 2006. All stakeholder bodies, including patient and public representative bodies, have a chance to comment during this process.

8. Even NHS officials who otherwise supported the proposals to merge PCTs have described the initial consultation process as "flawed". In some cases, organisations were given less than a month, during the summer holidays when many key figures were absent, to put together proposals for far-reaching changes to local services. The timing also meant that many local MPs and councillors were unable to contribute to the process. We accept that organisational change causes extreme instability, and for this reason it is helpful if periods of uncertainty are kept to a minimum. However, this needs to be balanced against the time needed both to consult local stakeholders, most importantly NHS patients, and to design new organisational structures that are fit for purpose. Our evidence suggests that in this case the Government has got this balance very wrong, particularly as the White Paper has not yet been published. (Paragraph 60)

As set out above, in our proposals set out on 28 July 2005 we asked SHAs to engage with their stakeholders in developing proposals which would then be subject to local consultation. The SHAs

had until 15 October 2005 to develop their proposals in consultation with local stakeholders – giving them a period of 11 weeks which ran well past the summer holiday period.

The draft proposals from the SHAs were to be submitted to the Department of Health by 15 October so that they could be duly assessed to see if they were fit for consultation before being sent out for a formal local consultation exercise.

The local consultations began on 14 December 2005, to run for 14 weeks until 22 March 2006. Now is a key time for ensuring that all local stakeholders are fully involved in deciding which new arrangements will be best for patients.

Commissioning a patient-led NHS is not about changes to local services. Our policy is clear: decisions about service provision will be a matter for PCTs to determine locally.

9. The flawed nature of the pre-submission engagement makes the proper conduct of the formal three month NHS consultation starting on 14 December vital. The letter from John Bacon, Group Director Health and Social Care Services Delivery dated 30 November to SHA Chief Executives instructed them to "ensure that all options are presented fairly and given equal weight in your documentation" and said that "where there are sharply differing views on particular options, it would be desirable to engage the relevant PCT in preparing the document". But it is not clear how the Department of Health has ensured this has happened as the consultation documents issued by SHAs did not have to be approved by the Department. The Department of Health should ensure that the consultation is fairly conducted by all SHAs, especially where the External Panel has required SHAs to consult on additional or different options than those originally considered in the pre-submission engagement. Not to do so would leave the Department vulnerable to allegations that the result of the consultation process was pre-determined and a sham. (Paragraph 61)

The Government welcomes this recommendation, and entirely agrees that it is vital to ensure that the 14-week formal consultation process is properly and fairly conducted.

John Bacon reiterated this point in a further communication sent on 8 December 2005 to all SHA Chief Executives, which stated: "Responsibility for approving PCT consultations, ensuring they reflect the conditionality set out in my 30 November letter and that equal weight is given to all options, rests with the SHA." The letter stressed how important it was that particular attention was paid to this, and asked SHA Chief Executives personally to oversee the matter.

Following the consultation process, an independent external panel will be considering each of the SHAs' consultation reports on PCTs in detail before making recommendations to the Secretary of State. As part of this exercise, the panel will be looking for evidence that SHAs have given fair and equal weighting to all options for reconfiguration and, where this is not apparent, it is expected that this will be reflected in the recommendations the panel makes to the Secretary of State.

10. Despite the Government's repeated reassurance that this is not a 'top down' process, with change being imposed on local NHS organisations from central government, the evidence we have received from those working in the NHS at a local level suggests that it is exactly that. This is because, in their view, the most significant driver of these reforms is finance and so solutions that would best meet local needs are being overruled because they do not yield enough cost savings. Cost savings may be a legitimate and justified driver for reform, as we discuss later in this report. However, the Government must be explicit that this is its key objective. It is disingenuous to argue that these changes are being driven from

the grassroots of the NHS when NHS managers have been told that the solutions that would best meet the needs of their local populations will not be adopted because they will not produce sufficient cost savings. (Paragraph 67)

The Government does not accept the criticism that this is a top-down process. It is far from it. Rather than imposing a blueprint for the precise shape of future PCTs from the centre, we have asked SHAs to oversee the development of the plans locally because what is the right solution for one part of the country will not be the right solution for another. We know that many local communities and their Members of Parliament are actively engaged in the current consultation process.

Reducing management costs is one of the eight criteria against which the proposals for reconfiguration are being assessed. Taken together, these criteria will ensure that *Commissioning a patient-led NHS* is not just about financial saving, but about improved care for patients and better value for money for the taxpayer.

11. Another very serious concern raised in our evidence is that because of the uncertainty about the divestment of provider services, *SHAs are having to design new organisations without a clear understanding of what their ultimate function will be.* This could lead to the formation of organisations which are not fit for purpose, necessitating yet more reorganisations. (Paragraph 71)

The Government agrees with the Committee that the role and functions of the new SHAs need to be clear.

To ensure new organisations are fit for purpose, the high-level functions of proposed new SHAs and PCTs have been set out in the guidance issued to SHAs and PCTs before the start of the consultation.

A 'fitness for purpose' tool for PCTs is also being developed and will assess PCTs against agreed high-level functions. This will be piloted during the summer and will be available for full roll-out as the new organisations are established.

12. Because SHA senior managers are currently under threat of redundancy, not only are they having to draw up reconfiguration plans whilst 'distracted by thoughts of self-preservation', but also, in all likelihood, will no longer be in post next year to be held accountable for the reconfiguration decisions they have taken. We find this highly concerning. The Government should have taken this into consideration and planned its restructuring accordingly, first ensuring existing SHAs have an ongoing role in overseeing and being held accountable for their PCT reforms, and then changing the configuration of SHAs themselves, rather than reforming both types of organisation in tandem, threatening both the quality of, and accountability for, these reforms. (Paragraph 73)

The Government agrees with the spirit of this recommendation – that clear accountability during the transition period is important alongside ongoing accountability for ensuring that new configurations at SHA and PCT level deliver improved services for patients. But we do not agree that this means PCTs should be established first.

In order to achieve this accountability, the Government believes it is important that the new SHA configuration is established first, allowing these bodies to give strategic leadership in their local health economy during the period of PCT transition.

The Department of Health has agreed clear transition arrangements with SHAs so that all remain accountable for ongoing performance and for agreeing local delivery plans for 2006/07. Additionally, transition leads for SHA clusters have been identified to ensure business continuity should new SHAs be agreed by Ministers following consultation.

Work is also proceeding on SHA and PCT fitness for purpose assessments, so that all new organisations, and those that continue in their current form, have the capacity and capability required by the new NHS commissioning model.

13. We are pleased that Lord Warner has given us a commitment to publish all information submitted to the external panel as soon as possible. It is essential that the external panel's responses are made public also. We also note that the Secretary of State has promised that all proposals that have not been subject to extensive local consultation will be rejected. From our evidence alone, it would appear that insufficient consultation has taken place in several areas, and we urge the Government to make clear at the earliest opportunity which proposals have been rejected. (Paragraph 75)

In his evidence session before the Committee, Lord Warner said he would see if we could make public information that was shared with the external panel. With the exception of materials that are considered to be covered by section 36 of the Freedom of Information Act 2000, information submitted to the external panel is available publicly.

14. In the light of our evidence, we believe that further steps must be taken to ensure that what remains of the formal consultation process in respect of changes to PCTs is as transparent and inclusive as possible, offering patients and other local stakeholders a genuine choice over how their local health services are structured. To achieve this, the Government must publish all documents submitted to its external panel as soon as possible; furthermore Ministers must ensure that all formal consultation is conducted in a fair and unbiased manner. (Paragraph 76)

As set out in our response to Recommendation 13, apart from materials that it is considered are currently covered by section 36 of the Freedom of Information Act 2000, documents submitted to the external panel are available publicly.

As set out in our response to Recommendation 9, the Government agrees that it is vital to ensure that the 14-week formal consultation process is properly and fairly conducted.

John Bacon made this point in a communication sent on 8 December 2005 to all SHA Chief Executives, which stated: "Responsibility for approving PCT consultations, ensuring they reflect the conditionality set out in my 30 November letter and that equal weight is given to all options, rests with the SHA."

Following the consultation process, the external panel will look for evidence that the SHAs have given fair and equal weighting to all options for PCT reconfiguration.

In considering the panel's recommendations on PCTs, the Secretary of State will also take into consideration any objections from stakeholders regarding the openness and fairness of the local consultation, before making any final decisions about the future configuration of PCTs in any particular area.

15. The evidence is clear: *the distraction caused by these reconfigurations will set back the development of PCTs' core functions, which include commissioning services, providing community health services, and protecting public health, by at least 18 months.* We consider that imposing a further structural change on organisations that are only three years old, at a time when pressure on those very organisations to perform well has never been higher, is ill-judged in the extreme. (Paragraph 85)

The Government simply does not accept that these changes will set services back 18 months, or indeed at all. This reconfiguration is not a sudden change. It is part of a planned and managed programme of NHS reform aimed at delivering improved quality of care for patients and value for money for taxpayers.

We have already seen this starting to happen as the NHS itself has recognised that change is necessary in order to deliver the next stage of the reform programme. The *Commissioning a patient-led NHS* programme allows this to be taken forward as part of a managed process.

16. There are also well-founded concerns that patient care will suffer as a direct result of the distraction caused by these reforms, and our evidence suggests that the destabilising effects are already being felt across the NHS, with clinical staff moving from community hospitals to the acute sector because of uncertainty over their future roles. It is highly ironic that while a key plank of Government health policy is now to move services away from the acute sector and strengthen community health care services, the uncertainty generated by these mismanaged policy announcements is having precisely the opposite effect, causing a drift of staff away from community health services back to the acute sector, which is now perceived as more stable. That some of these outcomes could, with more rational and coherent planning, have been predicted and avoided, makes the Government's actions in this area even more indefensible. (Paragraph 86)

The Government cannot accept the Committee's view that "patient care will suffer". *Commissioning a patient-led NHS* is about improving patient care – stronger commissioning will ensure that patients benefit from the right care, and can access this more conveniently and more quickly than ever before.

As mentioned earlier in our response, the Government recognises that change causes uncertainty for staff. The vast majority of NHS staff will be unaffected by any restructuring and it is very unlikely that any frontline clinicians will be directly affected. These changes are being made to NHS management organisations – PCTs and SHAs – not to hospitals.

Of course, it is very important that organisational change is managed effectively and the human resources framework we mention in our response to Recommendation 6 will be crucial in supporting staff throughout this period.

17. We strongly support the Government's desire to improve commissioning in the NHS, but believe that this should have been addressed before, or at least at the same time as powerful incentives were being introduced which strengthened the provider sector. The fact that it was not has given rise to an uneven balance of power in the NHS that may now prove difficult to redress. We are pleased that the Department of Health has acknowledged this, and we hope that in future it will make efforts to ensure that the wider impacts of its policies are considered at a system level to avoid such a situation arising again. (Paragraph 90)

The Government welcomes the Committee's comments about its work to improve commissioning and develop a commissioning-led delivery model. The importance of this is reflected in the conclusions of the recent review of the high-level structure of the Department of Health, and has led to the establishment of a new post of Director of Commissioning.

The Department of Health is working to ensure that policy is made and implemented with a whole system perspective. *Health Reform in England: update and next steps*, published in December 2005, describes the individual elements of Government reforms to the healthcare system and how they are expected to interact. It explains how our reforms are intended to reinforce each other and it lays out the next stages in policy development. The follow-up document, *The NHS in England: the operating framework for 2006/7* sets out the specific business and financial arrangements for the NHS for 2006/07, again taking a whole system view.

18. While larger PCTs may be able to wield greater bargaining power over the acute sector, research evidence demonstrates that increases in PCT size beyond populations of 100,000 patients do not necessarily generate substantial improvements in overall performance, and that optimal size for commissioning varies widely according to services being commissioned. Health Authorities were large commissioning organisations, and their size does not seem to have made them effective commissioners. Arguably, the introduction of Payment by Results may already be giving PCTs the levers they need to commission effectively from the acute sector, without the need for restructuring. (Paragraph 96)

The Government agrees with the Committee that the 'one size fits all' approach – for organisation size or population size – is not necessarily appropriate for PCT commissioners. This was the conclusion of a wide range of research that the Department of Health commissioned and considered prior to publishing *Commissioning a patient-led NHS*.

However, the landscape of the NHS has changed significantly in recent years. The Government's reform programme has brought about many improvements in patient care, including major reductions in waiting times for hospital treatment and significant increases in the number of doctors, nurses and other staff. In order to build on these recent successes, the NHS has been telling us – through PCT mergers and collaborative commissioning arrangements – that structural change is needed.

The Government agrees with the Committee that the size of an organisation does not necessarily mean that it will be an effective commissioner. Nor can we look to the past and think that the old model of Health Authorities is able to deliver good commissioning today. For this reason, the reconfiguration process is being underpinned by an organisational development programme to support PCTs in improving their commissioning capability. This aims to ensure that all PCTs get the help they need to achieve the standards set by the best.

19. We recognise the need to improve commissioning skills within PCTs. However, we remain unconvinced that instigating large-scale structural reform in order to 'retrench' commissioning expertise in larger centres is the only, or indeed the best, way to achieve this. Equally, it seems illogical that, at precisely the time the Government has committed to improving NHS commissioning, it is currently planning to spend £250 million less per year on this crucial function, further depleting management expertise from an already under-managed health system. This is more likely to weaken rather than strengthen NHS commissioning. (Paragraph 101)

The Government thanks the Committee for its recognition of, and support for, the need to improve commissioning skills within PCTs.

As mentioned above, the Government agrees with the Committee that an organisation's commissioning capability depends on more than size alone (see response to Recommendation 18).

The Government would like to stress that delivering £250 million savings does not necessarily mean that less will be spent on this crucial function. The £250 million savings are being generated from economies of scale and merging 'back office' functions. At the same time it is possible that one result of the reconfiguration exercise will be increased spending on the commissioning function – with the added aim that stronger commissioning will deliver better value for money for the NHS and the taxpayer.

20. In principle, we support the aim of improving joint working between the NHS and local authorities, both in respect of social services, and other crucial local functions including housing, regeneration and education services. However, we are concerned that these reforms, while offering an opportunity to better align some boundaries, may risk setting up new barriers in other areas, and may threaten existing joint working arrangements. (Paragraph 105)

The Government welcomes the Committee's endorsement of its policy to strengthen joint working between the NHS and local authorities.

We expect the reconfiguration greatly to improve on the current situation where some 40 per cent of PCTs are co-terminous with social services. We think this should rise to around 80 per cent. But achieving co-terminous boundaries is not the only consideration. Local reconfiguration proposals will be judged against eight criteria, including how organisations will improve commissioning, their effective use of resources and how they will manage financial balance and risk. So, while co-terminosity is important, it is not the sole determinant of the new configuration.

We are clear that maintaining existing joint working arrangements is very important. For those SHAs who propose fewer, larger PCTs, we have asked for evidence to demonstrate how existing successful partnerships with local partners can be maintained and improved. We have asked SHAs who opt to keep smaller PCTs to demonstrate how the necessary improvements in commissioning services can be delivered within existing structures.

21. PCTs were established to ensure that decisions about the NHS were made locally. By reverting back to the more remote structures that were abolished only three years ago, this localism will be lost. At the moment, each of the 302 PCTs in England has several Non-Executive Directors; a Patient and Public Involvement Forum; and a Professional Executive Committee of key local clinicians. While these structures clearly have a cost, they were introduced to add value. It is not clear why the Government is now unwilling to meet the cost of securing an enhanced level of local input into the NHS, only four years after this was identified as a key aim of Government health policy in Shifting the Balance of Power. Whatever the size of future PCTs, it is essential that structures to ensure clinical engagement and, most crucially, patient and public engagement are retained at their current levels, covering each natural community. (Paragraph 117)

The Government agrees with the Committee that it is important that structures for engaging with clinicians and patients are not lost through this reconfiguration process. However, it is not only

small organisations that can have an effective local presence – what matters more than the size of the organisation is the quality of its engagement processes and its people.

The Government is committed to ensuring that PCTs have skilled Professional Executive Committees (PECs) selected through a rigorous appointments process.

At the same time, *Commissioning a patient-led NHS* has accelerated the speed with which Practice Based Commissioning will be rolled-out. This will bring commissioning closer to patients, rather than becoming more remote as the Committee suggests. Practice Based Commissioning engages clinicians in local commissioning decisions in order that services are better able to meet the needs of local patients. A Directed Enhanced Service (DES) to support Practice Based Commissioning has been negotiated under the GMS contract for 2006/07 which will be available for practices from April 2006.

22. Practice Based Commissioning is a crucial policy which underpins the Government's proposals for restructuring PCTs, which the Government hopes will both strengthen commissioning and secure greater local engagement. However GPs, who will be responsible for implementing Practice Based Commissioning, have described a 'woeful lack of information' about the scheme, with key questions still unanswered. We therefore consider it highly unlikely that this system will be functioning effectively in all areas by the end of next year, and are concerned at the Government's complacency and unwarranted optimism over the implementation of Practice Based Commissioning. We urge the Government to address this lack of information immediately. (Paragraph 130)

The publication of *Practice based commissioning: achieving universal coverage* (January 2006) sets out the detailed arrangements for practices and PCTs to ensure universal coverage of Practice Based Commissioning by. Supporting guidance, *Practice Based Commissioning: early wins and top tips* (February 2006) provides case study examples and practical tips for practices.

23. The Minister's view that Practice Based Commissioning as it is currently conceived will improve patient and public involvement in health care is not firmly based on any evidence. In fact, there is a significant gap in this area. We recommend that the Government places a specific requirement on all practice based commissioners to establish regular, formal arrangements for securing the input of their patients and local populations in the commissioning and provision of local services, just as PCTs and other NHS trusts are obliged to. (Paragraph 131)

The Government agrees that it is important for local patients and populations to have robust involvement in the commissioning and provision of local services. The guidance *Practice based commissioning: achieving universal coverage* (January 2006) sets out the criteria for business cases for new services and these include that new services must be judged against patient and stakeholder support. The guidance also states that PCTs have a duty to involve and consult patients and the public when considering new or different service provision. It also encourages practices to engage patients and service users in decisions about the allocation of freed-up resources resulting from redesigned services.

24. We are also concerned at the complacent attitude that the Government is displaying towards the very real possibility of Practice Based Commissioning introducing perverse incentives that could threaten patient choice and access to health care. It seems to us that these problems have not yet been fully anticipated or considered by the Government, which is worrying given that they hope Practice Based Commissioning will be universally

implemented within a year. These potential problems need to be addressed before they arise, and to this end we recommend that the Government publish details of what actions it intends to take to counter these risks before Practice Based Commissioning is universally implemented next December. (Paragraph 132)

The Government agrees that patient choice and access to services are important drivers of the overall reform programme, and believes that the roll-out of Practice Based Commissioning will support these.

Under the patient choice initiative, patients will be offered four or more choices of provider when they are referred to hospital for elective (non-emergency) care. If, under Practice Based Commissioning, GPs or practices become providers of elective services, they will be able to become one of a menu of providers. Patients will have the right to choose between these elective care providers. GPs and other primary professionals have regular contact with patients and will therefore be in a unique position to support patients in making the most appropriate choice.

The White Paper *Our health, our care, our say* (January 2006) encourages provision of services in community settings which are more convenient for patients and closer to home. Practice Based Commissioning will support this shift.

Under Practice Based Commissioning, GP practices have a greater role in influencing the services that are commissioned for their patients. The PCT, however, retains the legal accountability for providing services to its population and must therefore ensure that services are provided to all patients. Proposals for new and different services, and for the re-investment of freed-up resources, must be signed off by the PCT which will ensure that the services are appropriate and meet the needs of the whole of its population.

The White Paper *Our health, our care, our say* sets out the arrangements for dealing with practices that have patient lists that are open but full. The PCT retains the responsibility for ensuring that GP services available through registration on a general practitioner list are made available to all patients within the PCT population.

Under their primary care contracts, practices are not allowed to refuse patients access to their lists on the grounds of race, gender, social class, age, religion, sexual orientation, appearance, disability or medical condition. Taken together these measures should ensure access to high-quality health services for all patients.

25. Evidence from those working in the NHS suggests that PCTs are collaborating with one and other and, as a result, bringing about improvements without the need for large-scale reorganisation. In our view, Lord Warner's suggestion that improvements in PCTs have been "patchy" does not constitute a valid argument for imposing radical structural reform across the board, dismantling organisations that are performing well as well as those that are performing badly. A more rational, constructive approach would be to support the evolutionary changes that are already taking place. (Paragraph 143)

The Government notes the Committee's recommendation that PCT reconfiguration could have proceeded in a more evolutionary way. However, while that approach would have seen winners it would also have seen losers.

As evidence to the Committee suggests, commissioning in the NHS has not developed as effectively or as consistently as it needed to over the last five years. There is best practice but this

is far from universal. In that context, it is apparent that a clear national framework is needed to enable all PCTs to meet the same high standards in commissioning that the very best are achieving, while acknowledging that no single organisational model will ever fit all.

Commissioning a patient-led NHS set out clearly what that framework would be and what is required of SHAs and PCTs.

26. As a senior NHS chief executive told us, there is no such thing as a 'Holy Grail' of a perfect size for a commissioning organisation. There is a clear trade-off between the increased bargaining power and better co-terminosity of larger organisations, and the enhanced local engagement of smaller PCTs. Practice Based Commissioning may achieve local clinical engagement, but will leave serious gaps in terms of patient involvement. In order to improve commissioning, PCTs need better skills and information systems. Restructuring is not necessary to achieve this. (Paragraph 144)

The Government agrees that there is no 'Holy Grail' in relation to the perfect size for a commissioning organisation. For this reason the local NHSs were asked to develop a local consensus on the PCT options that they would recommend go forward for consultation.

We agree with the Committee that PCTs need a combination of better skills and information systems, as well as restructuring, in order to improve commissioning. However, as Lord Warner said in his evidence to the Committee, this has happened "patchily" across the country. The PCT development programme aims to equip PCTs to be good commissioners, which will mean, among other things, they are able to analyse and understand patients' needs, negotiate with service providers, contract effectively and ensure value for money in all their commissioning activity.

27. Given our evidence that the majority of PCTs are already involved in successful collaborative working, we believe that the most effective way to improve commissioning is to allow PCTs to develop organically, enabling them to evolve into larger organisations where this clearly best meets local needs. A managed approach to sharing best practice should be adopted to ensure that the poorest performers learn from the expertise of the best performers, and support should be specifically targeted towards developing commissioning in the poorest performing PCTs. (Paragraph 145)

There is a significant gap between the 'best' and 'worst' local commissioning organisations. The Government agrees that it is important to encourage quality improvements across all organisations, and particularly to ensure that the worst organisations can be brought up to the standards of the best.

We think that this is most likely to be achieved by co-ordinating a national programme, which includes restructuring led by the NHS, combined with a national 'fitness for purpose' PCT development programme.

28. We were very concerned to learn that, prior to the publication of *Commissioning a patient-led NHS*, there was no consultation with public health professionals at all about its potential impact on PCTs' crucial public health function. In our view, debate about *Commissioning a patient-led NHS* has also given insufficient prominence to this. In order to safeguard local public health initiatives, we recommend that where PCTs merge leaving only one Director of Public Health, other consultants in Public Health are retained with responsibility for public health delivery, working with local authorities and local strategic partnerships. Further to this, steps must be taken to provide continuing support to

community health professionals who play an equally important part in securing public health improvements. (Paragraph 155)

Guidance on *Commissioning a patient-led NHS* issued by the Department of Health in July 2005 highlighted that the organisational reconfiguration for commissioning would be expected to consider how best to establish "a fit for purpose health system to deliver high quality care and value for money, alongside the improvement of health promotion and protection" (Paragraph 2, page 3).

The guidance also stated that the changes in PCT functions may or may not involve mergers and reconfiguration. Where they involve mergers, with a consequent reduction in the numbers of PCTs, this will also result in a reduction in the numbers of Directors of Public Health. However, the Department of Health is working to ensure that the overall numbers of public health posts are not reduced.

A letter issued by the Department of Health on 3 October 2005 to SHA Finance Directors, stated that SHAs and PCTs have already demonstrated in their Local Delivery Plans a commitment to an increase in capacity and capability to respond appropriately to the White Paper, *Choosing Health: Making healthy choices easier*. For this reason SHAs and PCTs should not identify for savings those posts working on the local delivery of *Choosing Health*. The savings target therefore excludes all consultant and specialist public health posts and posts working on frontline services, for instance health protection, smoking cessation services and other health improvement services outlined in the White Paper.

Choosing Health includes an overall strategy to develop and build capacity for health improvement at all levels of the system, and this remains an important ongoing national priority.

29. The Government has downplayed the financial motivation for these reforms, concentrating instead on its aim of strengthening commissioning. However, our witnesses were clear that this was the key consideration in drawing up plans for reform, to the extent that plans which would better meet local needs were discounted because they did not yield sufficient savings. While achieving efficiency savings is a legitimate aim, this needs to be stated explicitly so that it can be subject to proper scrutiny. (Paragraph 164)

As stated earlier, financial saving is not the only consideration. Plans for local PCT reconfiguration will be judged against eight criteria, including how organisations will improve commissioning, improved co-ordination with social services, effective use of resources and effective management of financial balance and risk. So, while financial savings is important, it is not the sole determinant of the new configuration.

30. In fact, the evidence to date suggests that this reconfiguration is unlikely to yield the savings the Government is hoping for. Figures put to us by PCT officials suggested that current proposals for reconfiguration might save between £60 and £135 million, well short of the target figure of £250 million. If proper clinical and patient involvement is to be retained, further local structures will need to be put in place at a sub-PCT level, which will generate additional costs. Equally, the costs of Practice Based Commissioning, which are at present unclear, will need to be taken into account. The NHS will also have to bear costs associated with redundancies, as well as the cost of reduced productivity over the next 18 months. (Paragraph 165)

Each SHA has submitted plans confirming that it will achieve its share of the £250 million savings. These plans will be firmed up once reconfiguration plans are approved. Savings are unlikely to fall

proportionately over all PCTs, so extrapolation from one PCT's savings will not provide an accurate estimate of total savings. Initial costings demonstrate, however, that PCT severance costs can be covered from savings between now and December 2007.

31. It is vital that NHS organisations deliver value for money. However, while the enhanced local perspective PCTs have brought to the NHS clearly has a cost, the benefits they have brought may well justify this cost. In addition to this, PCTs are currently responsible for spending 80% of the NHS's £76 billion budget. At a time when PCTs' commissioning role is crucial to the success of the NHS, it is a false economy to deplete the NHS's managerial resources still further in an attempt to save only a fraction of that total amount. (Paragraph 166)

Outline SHA plans demonstrate significant savings from Board costs and from economies of scale resulting from shared administrative services across more than one PCT.

The Government would like to make it clear that any reduction in the number of managers is not being driven through without due consideration of the after-effects. In fact, we acknowledge that in some cases there will be a need for greater management capability – the fitness for purpose development programme will identify those areas where organisations need to improve their management function.

However, in other cases, we believe that there are too many people doing the same job. We do not necessarily need over 300 contracting teams, planning teams, invoicing teams, and so on. The restructuring will allow some of these teams to merge, bringing their expertise together. To give an example, at the recent Opposition Day debate on 7 February, Mr Robert Flello MP described the benefits the Donna Louise Trust would gain by being able to work more efficiently with fewer commissioning bodies than the current PCT configuration allows.

32. Whether or not PCTs should divest themselves of their provider services is a huge question which is outside the scope of this short inquiry. However, inevitably our witnesses raised many important concerns about the divestment of PCT provider services, most notably that it would lead to fragmentation of services, and make joined-up care even harder to deliver. Equally, it is not clear whether sufficient alternative providers exist to provide a market in community services. We urge the Government to address these crucial questions in its forthcoming White Paper on out-of-hospital care. (Paragraph 181)

PCTs are no longer required to stop providing services directly. Instead, from 2007 they are required to review the services they commission (including services they provide themselves) to ensure they are delivering value for money, quality and equity. Only if directly provided services fail this test will PCTs have to seek alternative provision.

The White Paper is also committed to strengthening alternative providers of community health and social care services through establishing a social enterprise unit in the Department of Health and a fund for social entrepreneurs. We will also consider issues such as IT and workforce which make it difficult for the third sector to compete on a level playing field.

33. We were extremely concerned at evidence we received about proposals to tender out the commissioning function in Oxfordshire before the new PCT Board has even been appointed. When we put this to Lord Warner he reassured us that this would not be allowed to happen, and we are relieved to see that Thames Valley SHA has now reconsidered its plans. However, we believe that the idea of outsourcing commissioning represents a

significant departure from current policy, which has the potential of reducing transparency about the disposal of public funds. Further consultation and discussion is absolutely crucial before the Government allows any PCT to proceed down this route. (Paragraph 187)

As Lord Warner said in his evidence session before the Committee, there are no proposals to put out to private tender the delivery of the commissioning function of PCTs in any area.

As part of the proposals for PCT reconfiguration, one SHA proposed to procure an external management team to run one of its newly-proposed PCTs. However, this proposal will not be considered during the forthcoming local consultation as it is for the new PCTs, not the current SHAs, to decide how best to manage their responsibilities after reconfiguration.

If the new PCTs do decide to pursue this option in the future, decisions will of course be subject to public consultation.

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